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Correspondence

Letters to the Editor should not exceed 500 words.

Treatment of the Phobic Anxiety State

SIR,—The large number of patients involved and the severely incapacitating nature of their illness make your recent articles on phobic anxiety state welcome and valuable (22 February, p. 489 ; 1 March, p. 559 ; and 8 March, p. 619). I doubt, however, whether it is fully realized how many patients continue to suffer anything from 10 to 40 years with these distressing symptoms. Until recently there was little hope of relief by ordinary psychotherapy and social treatment methods. Fortunately the whole outlook regarding treatment has changed for the better since the introduction of monoamine-oxidase inhibitor drugs[1] and the advent of behaviour therapy, both of which are considered favourably in these articles. I feel, however, that the authors can be criticized for making the whole subject of treatment unnecessarily complicated.

On going through our hospital and other records, my colleagues and I at St. Thomas's and elsewhere find that we have treated between us over 450 patients with phobic anxiety states in the last few years. Most have ben treated with monoamine-oxidase inhibitor drugs. What started as a trickle of patients has now become a veritable torrent. They are apparently being sent by fellow sufferers who have themselves received relief, or by doctors who have seen other patients get better with, but are themselves nervous about, prescribing the monoamine-oxidase inhibitor drugs.

We hope to publish shortly a detailed analysis of over 200 of these patients who have been followed up for a year or more. About 80% of them are improved, and this includes some who had been ill for between 20 and 30 years. If the anxiety states are accompanied by normal sleep pattern only monoamine-oxidase inhibitor drugs are required, and occasionally chlordiazepoxide. If the patient's sleep is impaired, specially by early morning waking, then we consider that monoamine-oxidase inhibitor drugs should be given during the day and a tricyclic antidepressant should also be given in the evening to try and get a return to normal sleep pattern. Very little psychotherapy has been required.

The patients, however, must be strongly encouraged to tackle the phobic situations while the somatic effects of anxiety are being damped down by the monoamine-oxidase inhibitor drugs. Treatment with drugs may also have to be continued for up to five years or more in some of these patients. But as they may be ill for over 30 years without them this fact must be seen in the proper clinical treatment perspective. As already emphasized by Frommer[2,3] children with phobic anxiety states seem to respond to the monoamine-oxidase inhibitor drugs just as well as adults, and because of their obsessional natures are often more careful than adults about not taking cheese, etc. No problems have arisen in the skilled use of the monoamine-oxidase inhibitor drugs in children, and we have over 50 of them helped in our series to be published shortly.

Despite what the writers of these articles say, we continue to find it safe to combine a monoamine-oxidase inhibitor drug during the day with a tricyclic drug at night in properly adjusted dosages. And if this only is done many more patients are helped. In fact, if a lot more monoamine-oxidase inhibitor drugs with added tricyclics were to be given to these severely suffering and incapacitated patients with phobic anxiety states, and much less potentially addictive and dangerous sedatives, hundreds of patients all over the country could be helped by ordinary general practitioners with very little need for all the other treatments mentioned in these three articles. There will, however, be a number of patients with specific phobias, and much less free-floating anxiety, who will be greatly helped by the additional use of behaviour therapy. But the monoamine-oxidase-inhibitor drugs should be tried first as they are so much simpler to use.—I am, etc.,

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REFERENCES
1 Sargant, W., and Dally, P., *British Medical Journal*, 1962, 1, 6.
2 Frommer, E. A., *British Journal of Psychiatry*, 1968, Special Publication No. 2, p. 117.
3 Frommer, E. A., *British Medical Journal*, 1967, 1, 729.

Nature of Osteopetrosis

SIR,—I have read with interest your article on the management of metabolic bone disease (8 March, p. 621). I would like to comment on the statements concerning generalized osteosclerosis (osteopetrosis). These have over the years been repeated almost word for word from one book or article to another, and are quite incorrect. During the last few years I have had the opportunity of examining histological sections from a number of cases in Britain, as well as the collection available at the Armed Forces Institute of Pathology in Washington.

As stated in your article, bone formation is normal, but in so far as cell behaviour is concerned bone resorption and remodelling are also normal. The cortical bone, owing to a hindered blood supply, is often somewhat porotic, so that frequently a larger number of osteoclasts than normal may be observed. The lesion is in the organic intercellular matrix of the growth cartilage. This becomes more heavily calcified than normal, and the calcified cartilage then resists all normal resorption processes, remains permanently in the bone, and so causes morphological disturbances. It is the presence of this excess